STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004972	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	8111 S EMERSON AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint. Complaint: #IN00127511 Substantiated, no deficiencies related to allegation are cited. Date of Survey: 08-20-13 Facility number: 004972 Surveyor: John Lee, R.N. Public Health Nurse Surveyor Franciscan St Francis Health - Indianapolis is in compliance with 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules. QA: claughlin 09/10/13	S 000		